CANCER REPORTING IN CALIFORNIA:
ABSTRACTING AND CODING PROCEDURES
California Cancer Reporting System Standards, Volume I

Changes and Clarifications –18th Edition
December 2, 2019

Updates to Volume I-Release #3

GENERAL CHANGES

Select Pages
- ✓ Formatting and general typo updates.
- ✓ Confirmed page breaks.
- ✓ Updated Table of Contents.

SECTION CHANGES

Preface
- ✓ Changed region name from “Cancer Surveillance Program” to “The Los Angeles County Cancer Surveillance Program”.

II.1 CCR Reportability Guide
- ✓ Added Coding Instruction:
  - o If a case has a reportable histology for 2018 forward and was diagnosed with that histology prior to 2018:
    - ▪ Do not go back and report for 2017 because the histology was not reportable then. Report the date of diagnosis when case first became reportable in 2018.
- ✓ Removed the following note under Site Specific Terms Indicating In-situ Behavior heading: INTRAEPITHELIAL NEOPLASIA Note: (8077/2 and 8148/2) MUST be documented exactly as stated here. Grade III MUST be included in the diagnosis for these to be reportable. No variation in terms allowed.

III.3.3 Date of Diagnosis
- ✓ Updated Coding Instruction:
  - o Forth bullet and sub-bullets - For non-analytic cases where there is no information about the date or at least year of diagnosis, the instruction has been modified to read:
    - ▪ Use the date of admission /1st contact year as the date of diagnosis and apply the applicable coding instructions.

III.3.5 Class of Case
- ✓ Updated Codes table, Class 00 - To avoid confusion the example was moved from under the notes listed to above them.

IV.2 Diagnostic Confirmation
- ✓ Coding Instructions, second bullet - Reworded the instruction to be in alignment with standard setters.

V.3.3.1 In-Situ Coding

- ✓ Removed the following note under Site Specific Terms Indicating In-situ Behavior heading - INTRAEPITHELIAL NEOPLASIA Note: (8077/2 and 8148/2) MUST be documented exactly as stated here. Grade III MUST be included in the diagnosis for these to be reportable. No variation in terms allowed.

V.5.1 Tumor Size Clinical - ***NEW***

- ✓ Coding Instructions, third bullet - Added second sub-bullet and note.
  - Record the size from an incisional biopsy. Use the clinical guideline for TNM to determine if the biopsy was done during the clinical timeframe. **Use the source that gives you the best size and take the largest size.**
    NOTE: An incisional biopsy that removed the whole tumor is actually an excisional biopsy. Record tumor size from an excisional biopsy in Tumor Size – Pathologic.

V.8 Terms Indicating In-situ for Staging

- ✓ Removed the following note under Site Specific Terms Indicating In-situ Behavior heading: INTRAEPITHELIAL NEOPLASIA Note: (8077/2 and 8148/2) MUST be documented exactly as stated here. Grade III MUST be included in the diagnosis for these to be reportable. No variation in terms allowed.

V.11.1.3 EOD - Mets - ***NEW***

- ✓ Added Coding Instruction:
  - Eleventh bullet - Not all possible metastatic sites are listed in each of the schemas. If there is confirmed metastasis that is not listed, assign the highest code as described below:
    - Code 70 is used for all mets (except distant lymph nodes only), for schemas that have only codes 10 (distant lymph nodes) and 70 (all other mets.
    - For schemas where there are additional codes:
      - Use the highest code before code 70, when mets are present that are not specified in any of the other codes.
      - Code 70 in these cases should only be used when the only information is "distant metastasis, NOS," and there is no documentation regarding the specific metastases.

V.12 SSDI General Information - ***NEW***

- ✓ Added Coding Instruction:
  - First bullet - SSDIs are to be collected during the initial diagnosis, workup and first course treatment.
  - Sixth bullet - SSDIs follow the standard definitions of rounding.
    - All SSDIs that have lab values, percentages or measurements are set up to record in the 10ths (one digit after the decimal point).
    - If a lab value, percentage or measurement is recorded in 100ths (two digits after the decimal point), then the last digit must be rounded.
    - The general rounding rules are:
      - If digit is 0-4, round down
      - If digit is 5-9, round up
      - Currently, the only SSDIs that have exceptions to the general rounding rules are:
        - HER2 ISH Single Probe Copy Number
        - HER2 ISH Dual Probe Copy Number
        - HER2 ISH Dual Probe Ratio
  - Seventh bullet - Unless instructions for a specific laboratory test state otherwise, record only test results obtained.
    - Before any cancer-directed treatment is given (neoadjuvant therapy or surgical), AND
    - No earlier than approximately three months before diagnosis AND
    - If multiple lab tests are available, record the highest value

VI.2.5.3 Sentinel Lymph Nodes Examined

- ✓ Codes table - Removed code 90 – 90 or more nodes examined. This was a duplication and was not in any of our standard setter manuals.

VI.3.3.3 Radiation Treatment Modality - Phases I-3

- ✓ Added Coding Instruction:
  - Last bullet - Coding instructions for radiation modality based on the type of heavy equipment used for therapy, are located in the CoC's CTR Guide to Coding Radiation Therapy Treatment, Appendix B - Coding Modality for the Heavy Equipment of Modern Radiation Therapy.

IX.1.3 Deletions

- ✓ Bullet one , added sub-bullet - Deletions cannot be submitted for a case to be re-abstracted under a new reporting facility if the case was previously abstracted under another reporting source.
- ✓ Bullet three, added sub-bullet - Mass deletions must be approved by the regional or central registry in advance.

Appendix G: Codes for Casefinding

- ✓ Updated screening list for 2019-2020 ICD-10-CM Codes for casefinding tables.

Appendix J: Spanish Surnames

- ✓ Changed format of appendix to comply with Americans with Disabilities Act (ADA).